SYNOPSIS

The proposed amendment modifies the existing regulation in light of changes to the business operations of the State Health Benefit Plan (SHBP). Additionally, changes have been made to these regulations to reflect the passage of HB 1372.

EXPLANATION OF CHANGES

The section 111-4-1-.02(1)(c)(1) has been added to reflect that a Subscriber may be assessed a tobacco surcharge in an amount approved by the Board if either the Subscriber or one or more of his or her Covered Dependents have used tobacco products in the previous twelve (12) months. The surcharge amount shall be added to the Subscriber's Premium for the remainder of the Plan Year, unless the tobacco user completes a smoking cessation program or similar program designated by the SHBP. Failure to answer the surcharge question(s) will result in the Subscriber automatically be charged the surcharge.

The section 111-4-1-.02(1)(c)(2) has been added to reflect that a Subscriber may be assessed a spousal surcharge in an amount approved by the Board if the Subscriber elects to cover his or her spouse under the SHBP when his or her spouse is eligible for coverage through his or her employer but opts not to take that coverage. The surcharge will not be charged if the spouse is already eligible for coverage under the SHBP through his or her employer and the spouse answered the surcharge question(s) on-line. Failure to answer the surcharge question(s) will result in the Subscriber automatically be charged the surcharge.

The reference of eighteen (18) hours in 111-4-1-.02(d)(4) has been stricken and replaced with seventeen and a half (17 ½) hours so that the language is consistent with statutory requirements.

111-4-1-.02(e)(3) has been modified to reflect the various agencies with whom the DCH Board may contract for the inclusion of employees, retired employees, and dependents in the state health benefit plan.

The subsection 111-4-1-.02(e)(4) has been added indicating that the Board may contract with any qualified CDHP licensed to do business in Georgia.

The subsection 111-4-1-.02(1)(e)(5)(i) has been added which allows the Commissioner, upon written notice, to terminate coverage for Groups that either contract for SHBP coverage or that have been designated by applicable state law as eligible for coverage if the Group fails to remit either the Employer or Employee contributions.

The subsection 111-4-1-.02(1)(e)(5)(ii) has been added which allows the SHBP to reinstate coverage upon receipt of the required contributions from any Group that either contracts for SHBP coverage or is designated by applicable state law as eligible for such coverage.

The subsection 111-4-1-.02(1)(e)(5)(iii) has been added to reflect a current statutory provision that the Board may require specified Groups to provide a bond to ensure payment performance.

111-4-1-.02 Organization.

(1) **Functions, Duties and Responsibilities of the Board of Community Health.** The Board shall provide policy direction for the operation of the State Health Benefit Plan. Other responsibilities as defined by law are:

(a) **Establish and Design Plan.** The Board is authorized to establish a health insurance plan for group hospitalization and surgical and medical insurance against the financial costs of hospitalization, surgery, and medical treatment and care. The plan may also include, but is not required to include, prescribed drugs, medicines, prosthetic appliances, hospital inpatient and outpatient service benefits, dental benefits, vision care benefits, other types of medical expense and medical expense indemnity benefits. The Plan shall be designed to:

1. Provide a reasonable relationship between the hospital, surgical and medical benefits to be included and the expected distribution of expenses of each such type to be incurred by the covered Employees and dependents;

2. Include reasonable controls, which may include deductible and reinsurance provisions applicable to some or all of the benefits, to reduce unnecessary utilization of the various hospital, surgical and medical services to be provided and to provide reasonable assurance of stability in future years of the Plan; and

(b) **Promulgate Regulations.** The Board is authorized to adopt and promulgate rules and regulations for the effective administration of the SHBP; to adopt and promulgate regulations for defining the contract(s) for retiring Employees and their spouses and dependent children; to adopt and promulgate regulations for prescribing the conditions under which an Employee or retiring Employee may elect to participate in or withdraw from the SHBP; to adopt and promulgate regulations defining the conditions for covering the Employee's spouse and dependent children and for discontinuance and resumption by Employees of coverage for the spouse, surviving spouse, and dependents; to adopt and promulgate regulations to establish and define terms and conditions for former and terminated Employee participation; adopt and promulgate rules and regulations which define the conditions under which Employees who originally rejected coverage may acquire coverage at a later date; and adopt and promulgate rules and regulations for withdrawing from the SHBP upon eligibility for the aged program of the Social Security Administration.

(c) **Establish Subscriber Premium Rates.** The Board shall establish Subscriber premium rates for each Coverage Tier and Option. The Board shall consider the actuarial estimate of the SHBP costs and the funds appropriated to the various departments, boards, agencies, and school systems in establishing the Employee deduction amount. Other Subscriber premium amounts shall be established in accordance with these regulations. All Subscriber premium rates shall be established by resolution and shall remain in effect until changed by resolution.

1. **Tobacco Surcharge.** A Subscriber may be charged a tobacco surcharge in an amount approved by the Board if either the Subscriber or any of his or her Covered Dependents have used tobacco products in the previous twelve (12) months. The surcharge amount will be added to the Subscriber's base monthly Premium. Any Subscriber who fails to answer any designated question(s) relating to the surcharge during Open Enrollment will automatically be charged a surcharge for the remainder of the Plan Year, unless the tobacco user successfully

completes a tobacco cessation program, or other similar program, specifically designated by the SHBP.

2. **Spousal Surcharge.** A Subscriber may be charged a spousal surcharge in an amount approved by the Board if the Subscriber elects to cover his or her spouse and the spouse is eligible for coverage through his or her employer but opts not to take that coverage. Notwithstanding the foregoing, if the spouse is already eligible for coverage with the SHBP through his or her employment, and the spouse answered the surcharge question(s) on-line, the SHBP will not add the surcharge to the Premium amount. Any Subscriber who fails to answer any designated question(s) relating to the surcharge during Open Enrollment will automatically be charged the surcharge for the remainder of the Plan Year.

(d) **Establish Employer Rates.** The Board shall establish by resolution, subject to the Governor's approval, employer contribution rates. These rates may be a dollar amount, a dollar amount for each Employee, a percentage of salary or any other method permitted by law.

1. The employer contribution rate for teachers who retired prior to January 1, 1979 shall be a dollar amount as identified in the appropriations act.

2. The State Department of Education employer contribution rate for the public school employee health insurance fund shall be a dollar amount as identified in the appropriations act.

3. The local school system employer contribution rate for the public school employee health insurance fund shall be a dollar amount per actively enrolled public school employee and shall be remitted to the Administrator on a monthly basis. The employer's contribution amount shall be due on the first of the month coincident with the employees' monthly premium amounts.

4. The employer contribution rate for the teachers health insurance fund shall be a percentage of the salary approved by the State Board of Education under the Quality Basic Education Act for persons holding "Certificated Positions" or in a "Certificated Capacity". The monthly employer contribution shall be a percentage of state based salaries. County or district libraries shall pay as the employer contribution the Board approved percentage of total salaries, exclusive of per diem and casual labor, which is defined as part-time Employees who work less than ~~18~~ seventeen and a half (17 ½) hours per week. The contribution amount shall be due to the Administrator on the first of the month coincident with the Employees' monthly coverage payment. The Commissioner is authorized to establish necessary procedures to implement the receipt of the employer contribution on a timely and accurate basis.

5. The employer contribution rate for the State employees health insurance fund shall be a percentage of the total salaries of all Employees. Total salaries include temporary salaries, overtime pay, terminal leave pay, and all types of supplemental pay. The monthly employer contribution shall be based on salaries for the previous month and shall be due on the first of the month coincident with the Employees' monthly premium amounts.

(e) **Approve Contracts.** The Board is authorized to approve contracts for insurance, reinsurance, health services and administrative services for the operation of the Plan. The Board shall also approve contracts to include HMOs and Consumer Driven Health Plans as an alternative to regular insurance and approve contracts as authorized by law with governments, authorities, or other organizations for inclusion in the Plan.

1. **Insurance.** The Board may execute a contract or contracts to provide the benefits under the Plan. Such contract or contracts may be executed with one or more corporations licensed to transact accident and health insurance business in Georgia. The Board shall invite proposals from qualified insurers who, in the opinion of the Board, would desire to accept any part of the health benefit coverage. Any contracts that the Board executes with insurers shall require compliance with O.C.G.A. § 10-1-393 (b)(30.1) relating to certain unfair practices in consumer transactions. The Board may reinsure portions of a contract for the Plan. At the end of any contract year, the Board may discontinue any contract or contracts it has executed with any corporation or corporations and substitute a contract or contracts with any other corporation or corporations licensed to transact accident and health insurance business in Georgia.

2. **Self Insurance.** The Board in its discretion may establish a self-insured plan in whole or in part. The contract for Administrative Services in connection with a self-insured health benefit plan may be executed with an insurer authorized to transact accident and sickness insurance in Georgia; with a hospital service nonprofit corporation, nonprofit medical service corporation, or health care corporation; with a professional claim Administrator authorized or licensed to transact business in Georgia; or with an independent adjusting firm with Employees who are licensed as independent adjusters pursuant to Article 2 of Chapter 23 of Title 33.

3. **Local Governments.** The Board is authorized to contract with the various counties of Georgia, ~~to contract with~~ the County Officers Association of Georgia, the Georgia Cooperative Services for the Blind, ~~to contract with~~ public and private nonprofit sheltered employment centers which contract with or employ persons within the Division of Rehabilitation Services and the Division of Mental Health and Mental Retardation of the Department of Human Resources; and to contract with the Georgia Development Authority, the Georgia Agrirama Development Authority, the Peace Officer's Annuity and Benefit Fund, the Georgia Firefighters' Pension Fund, the Sheriffs' Retirement Fund of Georgia, the Georgia Housing and Financing Authority, any public or non-profit critical access hospital, the Georgia –Federal State Inspection Service for the inclusion of Employees, retiring Subscribers and dependents in the SHBP. The Board is further authorized to include the Georgia-Federal State Inspection Service Employees who retired under the Employees' Retirement System of Georgia on or before July 1, 2000. Each contract employer shall deduct from the Subscriber's salary the Subscriber's cost of coverage. In the case of the Georgia Development Authority, the Peach Officers' Annuity and Benefit Fund, the Georgia Firefighters' Pension Fund, the Sheriffs' Retirement Fund of Georgia, the Georgia Housing Authority, and the Georgia Agrirama Development Authority, the Retiree's cost of coverage shall be deducted from the Retired Subscriber's annuity payment. In addition, each contract employer shall make the employer contribution required for inclusion in the Plan and remit such payments in accordance with procedures as the Administrator may require.

4. **Consumer Driven Health Plans (CDHPs).** The Board may contract with any CDHP qualified and licensed to conduct business in Georgia pursuant to Chapter 21 of Title 33 of the Official Code of Georgia Annotated.

~~4.~~5. **Other Organizations.** The Board is authorized to contract with other organizations, including any public or nonprofit critical access hospital, and any federally qualified health center as defined in 42 U.S.C.A. 1395x(aa)(4), that meets such requirements as the Administrator may establish for the inclusion of the Employees and dependents in the SHBP. Each employer shall deduct from the Employee's salary the Employee's share of the

cost of coverage. Each employer shall remit the total premium amount as established by the Administrator for inclusion of its Employees in the Plan and in accordance with such procedures as the Administrator may require.

(i) **Coverage Termination for Failure to Remit Premiums.** Upon providing written notice, the Commissioner may terminate coverage for any Group that either contracts for SHBP coverage or is designated by applicable state law as eligible for such coverage for failure to remit either Employee or Employer contributions.

(ii) **Reinstatement of Coverage.** Upon remittance of the required contributions from any Group that either contracts for SHBP coverage or is designated by applicable state law as eligible for such coverage, the SHBP may reinstate coverage that has been terminated previously for failure to remit Premiums.

(iii) **Bond.** The Board may require that specified Groups provide a bond to ensure payment performance before allowing SHBP coverage.

~~5.~~6. **Health Maintenance Organizations (HMOs).** The Board may contract with any HMO qualified and licensed to conduct business in Georgia pursuant to Chapter 21 of Title 33, relating to health maintenance organizations.

~~6.~~7. **Local School Systems.** When a school system has elected not to participate in the SHBP for public school Employees, the Employees may petition the local school system to contract with the Board for an Employee-Pay-Group. The local system may contract with the Board after agreeing to:

(i) Collect the Subscriber premium amounts for the rates established by the Board; and

(ii) Enroll and maintain enrollment at 75% of the eligible public school Employees as defined in these regulations.

(2) **Functions, Duties and Responsibilities of the Commissioner.** The Commissioner is the chief administrative officer of the Department of Community Health. The Commissioner and Administrator as used in these regulations are synonymous. The Commissioner shall employ such personnel as may be needed to administer the SHBP, to appoint and prescribe the duties of positions, all positions of which shall be included in the classified service except as otherwise provided in the law, and may delegate administrative functions and duties at the Commissioner's discretion.

(a) **Administer Regulations and Policies.** The Commissioner shall administer the SHBP consistent with Board regulation and policy.

(b) **Custodian of Funds.** The Commissioner shall be the custodian of the health benefit funds and shall be responsible under a properly approved bond for all monies coming into said funds and paid out of said funds.

1. All amounts contributed to the funds by the Employee and the employers and all other income from any source shall be credited to and constitute a part of such trust funds. Any amounts remaining in such fund(s) after all expenses have been paid shall be retained in such fund(s) as a special reserve for adverse fluctuation.

2. The Commissioner shall establish accounting procedures for maintaining trust funds for the premium income, interest earned on the income and expenses and benefits paid. Any amounts remaining in each trust fund after all expenses have been paid shall be retained wholly for the benefit of the members who are eligible and who continue to participate in each health insurance trust.

3. The Commissioner shall submit to the Director of the Office of Treasury and Fiscal Services any amounts available for investment, an estimate of the date such funds shall no longer be available for investment, and when funds are to be withdrawn. The director of the Office of Treasury and Fiscal Services shall deposit the funds in a trust account for credit only to the Plan and shall invest the funds subject only to the terms, conditions, limitations and restrictions imposed by the laws of Georgia upon domestic life insurance companies.

4. The Commissioner may administratively discharge a debt or obligation not greater than $400.00 due the health insurance fund or funds.

(c) **Regulations.** The Commissioner shall recommend to the Board amendments to the regulations, submit the approved regulations to appropriate filing entities, cause all regulations to be published and provide a copy to the Employing Entities.

(d) **Elicit and Evaluate Proposals from Health Care Contractors and/or Administrators.** As required for the appropriate administration of the Plan, the Commissioner shall prepare requests for proposals for selection of health care contractors, vendors, or administrators. Upon receipt of the proposals, the Commissioner shall secure an evaluation of the proposals and submit recommendations for the selection of health care contractors, vendors, or administrators to the Board for approval.

(e) **Calculate Employer Contribution Rate.** The Commissioner shall cause to be calculated an average employer contribution rate for “single” coverage and an average employer contribution for “family” coverage for non-Medicare+Choice enrolled Subscribers based on the method specified in Section 111-4-1-.11(14) and 111-4-1-.11(16). The Commissioner shall present the employer HMO contribution rates and the Subscriber deduction/reduction amounts for each Option and Coverage Tier to the Board for adoption at least 60 days before the beginning of the State of Georgia’s Fiscal Year.

(f) **Premium Payments to a Contractor.** The Commissioner shall calculate the premium amounts due to each HMO and to any underwriter of insurance or re-insurance and remit payments from the appropriate trust funds for Subscriber coverage.

(g) **Develop and Publish Plan Document.** The Commissioner shall develop a Summary Plan Description (SPD) or certificate of coverage which incorporates the approved schedule of benefits, eligibility requirements, Termination of Coverage provisions, Extended Coverage provisions, to whom benefits will be payable, to whom claims should be submitted, and other administrative requirements. The Commissioner shall cause the Summary Plan Description to be printed and distributed to each local and state employer for each covered Subscriber. The Commissioner shall distribute the SPD to Retired Subscribers and to Extended Beneficiaries at their last known address.

(h) **Provide Identification Cards to Subscribers.** The Commissioner shall cause to be designed and printed an identification card for each enrolled Subscriber and dependent,

unless the Subscriber has elected coverage under an HMO. The Commissioner is authorized to mail Identification Cards directly to the Subscribers at their home address. The Commissioner may require the Employing Entity to distribute Identification Cards to Subscribers following Open or Special Enrollment periods. The Commissioner shall establish procedures for Subscribers to report dependents and shall acknowledge approval or denial of those dependents to the Subscriber through the Employing Entity. The Commissioner shall require that a Subscriber's dependents be reported and approved prior to payment of claims on the dependent. The Commissioner shall determine if failure to notify the Administrator of a new dependent within thirty-one (31) days after acquisition will eliminate the eligibility of that dependent, who may otherwise be eligible, until the next open enrollment period. If the determination is made to install this provision, Subscribers must be notified in advance and allowed a minimum of sixty (60) days to update their records prior to the implementation of this filing.

(i) **Provide Notice of Employer Contribution.** The Commissioner shall provide notice and certification of the required employer contribution rate to each of the Employing Entities and the Department of Education on or before June 1 of each year, if the rate for the ensuing fiscal year is to be modified. The Commissioner shall notify the Employing Entities before the rate is effective of any rate change which may be required at times other than the beginning of a fiscal year.

(j) **Provide Notice of Eligibility.** The Commissioner shall develop procedures for notifying beneficiaries of the Extended Coverage eligibility upon notification by the Employing Entity of the Subscriber's employment termination, death, or reduced hours or upon notification by the Subscriber of divorce, legal separation, or child no longer meeting the definition of dependent.

(k) **Provide Certification of Creditable Coverage.** The Administrator shall establish procedures for providing a certificate of creditable coverage to each Subscriber at the time coverage cancels or upon request of the Subscriber or Covered Dependent and for a period of twenty-four months after coverage cancellation. The Subscriber may use the certification to limit a subsequent plan's imposition of a pre-existing condition limitation or exclusion period. Coverage cancellation may be the result of termination of coverage through Employee deduction, termination of coverage at the end of an approved leave of absence without pay, or termination of coverage at the end of the Temporary Extended Coverage period.

(l) **Correction for Administrative Error.** An administrative error is defined as any clerical error in submitting pertinent records or a delay in making any changes by the Employing Entity or Administrator that affects the coverage for a Subscriber or dependent who has followed all established procedures and met the time deadlines regarding enrollment or maintenance of coverage. If the error has placed the Subscriber or dependent at a substantial financial risk or risk of loss of coverage, the facts shall be reviewed and corrective action taken. If the Administrator concludes that the Subscriber or dependent was substantially harmed, the Subscriber or dependent shall be restored to the former position or shall be granted the request in whole or in part. Any determination of an administrative error shall be left to the discretion of the Administrator and is not subject to challenge.

(3) **Duties and Responsibilities of Employing Entity.** Each Employing Entity is responsible for complying with these regulations. Statements made by the staff of the Employing Entities that are in conflict with these regulations, the Schedule of Benefits, Decision Guide, or the Summary Plan Description (SPD) shall not be binding on the Administrator.

Failure of the Employing Entities to fulfill the duties and responsibilities listed in these regulations does not negate the time requirements specified throughout these regulations.

(a) **Enroll Eligible Employees.** Each Employing Entity shall enroll or assist all persons who become full-time Employees and who are eligible under these regulations as Subscribers of the SHBP unless the Employee rejects or waives such coverage in writing. The Employing Entity shall require each eligible new Employee to complete, within thirty-one (31) calendar days of reporting to work, a form for enrolling or a form for declining or waiving coverage under the SHBP. The Employing Entity shall be responsible for collecting any premiums due for the selected coverage.

(b) **Deduct Subscriber Premium Amounts.** The Employing Entity shall withhold the Subscriber premium amount as approved by the Board, or the premium amount authorized by the applicable Georgia Code sections, from his/her compensation as the Subscriber's share of the cost of coverage under the Plan. Any retirement system under which retired or retiring Subscribers may continue coverage under the SHBP as an annuitant shall withhold the premium amount as approved by the Board from his/her annuity as the Subscriber's share of the cost of coverage under the Plan.

(c) **Remit Employee and Employer Amounts.** The Employing Entity shall reconcile their Employee's SHBP coverage records in the manner prescribed by the Administrator and remit the amount of premium deducted from the Subscriber's compensation or annuity within five (5) working days following the effective date of coverage. The Subscriber premium remitted by the Employing Entity to the Administrator shall equal the full, face amount of the premium due for the period coincident with the Subscriber's SHBP coverage, as reflected on the SHBP monthly billing statement. Each employer is responsible for reconciling the premium payments and the billing invoice to make any and all corrections to the records. This is to be done within thirty (30) days of receipt of the bill. Each Employing Entity, except for a retirement system, shall remit the employer contribution amount to the Administrator for the period coincident with the Subscriber's coverage month within five (5) working days of the due date.

1. The Employing Entity shall calculate and remit the appropriate employer contribution including administrative fees, for those Subscribers who elect to enroll or continue coverage during an approved Family Medical Leave Without Pay.

(d) **Provide Employee Enrollment Information to the Administrator.** Each Employing Entity shall make available to eligible Employees all educational and benefit enrollment information necessary for the Employee or Subscriber to make an informed health benefit plan decision.

(e) **Provide Plan Materials to Each Employee.** Each Employing Entity shall distribute the Summary Plan Description with UPDATER's and electronic enrollment information to each eligible Employee. Each Employing Entity shall make every effort to distribute other SHBP materials, including Open or Special Enrollment information, identifications cards, and information about the web site, to Employees at the request of the Administrator. When appropriate, each Employing Entity shall hold group meetings to explain a specific aspect of the SHBP to Employees.

(f) **Provide Leave Without Pay Information to Subscribers.** Each Employing Entity shall administer a Family and Medical Leave Program in compliance with the federal laws

and shall provide information regarding the conditions for continuing coverage under the SHBP to eligible Employees. Each Employing Entity shall also provide continuation of coverage information to Subscribers under other Leave Without Pay provisions of these regulations. Each Employing Entity shall insure Employees on approved leave of absence are properly notified of the annual Open Enrollment Period and afforded the opportunity to enroll or change coverage.

(g) **Provide Employee Termination Information to the Administrator.** Each Employing Entity shall report to the Administrator the date of the last deduction and/or the reason for the coverage termination no later than thirty (30) days following the employment termination or loss of eligibility to participate in the Plan through payroll deduction/reduction. The reasons for coverage termination shall be limited to: resignation, transfer, retirement, termination for gross misconduct, separation for reasons other than gross misconduct, reduced employment hours that affect coverage eligibility, lay-off, leave of absence without pay, discontinuation, and death. Any penalties assessed upon the Administrator for failure to comply with notification requirements as a result of the Employing Entity's failure to notify the Administrator shall be billed to the respective Employing Entity. The Employing Entity shall reimburse the Administrator in full for claim liability and expenditures incurred by the Plan as a result of the Employing Entity's failure to comply with notification requirements.

Authority: O.C.G.A. §§ 45-18-1 *et. seq.*, 20-2-881, 20-2-883, 20-2-884, 20-2-885, 20-2-891, 20-2-892, 20-2-893, 20-2-894, 20-2-895, 20-2-896, 20-2-911, 20-2-912, 20-2-913, 20-2-914, 20-2-915, 20-2-916, 20-2-918, 20-2-919, 20-2-920, 20-2-921, 20-2-922, 20-2-924, 31-5A and 20-2-55.